KELLER ARMY COMMUNITY HOSPITAL SELF-CARE PROGRAM
TREATMENT OPTIONS FOR SYMPTOMS/CONDITIONS**

1. By signing this form, I certify the following:

a) I do not wish to see a physician at this time.
b) I have no need for medical advice.
c) I will take medication according to labeled manufacturer's instructions only.
d) I am not using this medication listed for symptoms that have not resolved despite a visit to Mologne Health Clinic for this illness.
e) I have not taken an OTC medication in the past 14 days and will not take any other OTC medications while on the medication I am about to receive.
f) I am familiar with the Self-Care Class on the Keller ACH internet site under Pharmacy tab titled: SELF-CARE: OVER-THE-COUNTER (OTC) MEDICATIONS.

2. I fully understand that the OTC medication is only for my use in acute minor illness. If symptoms persist, worsen, or do not improve within 48 hours, I will consult a medical provider.

3. Further, I certify that I am NOT:

(a) on flight status
(b) pregnant
(c) allergic to any of the medications selected
(d) taking medications for high blood pressure
(e) using herbal/muscle enhancing supplements

I also verify that I am requesting treatment option(s) Voluntarily.

1. What ALLERGIES, to include Medications, do you have?

_____

2. What Medicines are you presently taking?

_____

3. Have you been seen within the past three days for the same symptoms? _____YES _____NO

Print Name:_____ Signature: _____

Sponsor's Last Four SSN:_____ **DOB** _____ **SEX: M or F (circle)**